

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	676	84	3,734	4,494	8
9	SNF/PED					9
10	ICF	32,614	1,534	2,292	36,440	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,290	1,618	6,026	40,934	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.56%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/02/1987

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/02/1987 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 150 and days of care provided 3,734

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **WINDMILL NURSING PAVILION** # **0031823** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			609,139	609,139	609,139		609,139			1
2	Food Purchase		621		621	621	(621)				2
3	Housekeeping		127	187,148	187,275	187,275		187,275			3
4	Laundry		7,349	104,152	111,501	111,501		111,501			4
5	Heat and Other Utilities			135,969	135,969	135,969	1,046	137,015			5
6	Maintenance	89,727	60,886	25,060	175,673	175,673	13,580	189,253			6
7	Other (specify):*			12,205	12,205	12,205	929	13,134			7
8	TOTAL General Services	89,727	68,983	1,073,673	1,232,383	1,232,383	14,934	1,247,317			8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000	6,000		6,000			9
10	Nursing and Medical Records	2,487,796	139,961	75,004	2,702,761	2,702,761		2,702,761			10
10a	Therapy	372,979	6,457		379,436	379,436		379,436			10a
11	Activities	131,367	16,426	2,418	150,211	150,211		150,211			11
12	Social Services	90,588		4,583	95,171	95,171		95,171			12
13	CNA Training										13
14	Program Transportation			150	150	150		150			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,082,730	162,844	88,155	3,333,729	3,333,729		3,333,729			16
	C. General Administration										
17	Administrative	103,254		19,200	122,454	122,454	213,236	335,690			17
18	Directors Fees										18
19	Professional Services			171,025	171,025	171,025	(34,165)	136,860			19
20	Dues, Fees, Subscriptions & Promotions			97,601	97,601	97,601	(48,147)	49,454			20
21	Clerical & General Office Expenses	276,195	26,921	631,112	934,228	934,228	(499,748)	434,480			21
22	Employee Benefits & Payroll Taxes			565,416	565,416	565,416		565,416			22
23	Inservice Training & Education			8,050	8,050	8,050		8,050			23
24	Travel and Seminar						1,950	1,950			24
25	Other Admin. Staff Transportation			11,972	11,972	11,972	1,528	13,500			25
26	Insurance-Prop.Liab.Malpractice			199,377	199,377	199,377	3,117	202,494			26
27	Other (specify):*			131,919	131,919	131,919	(65,732)	66,187			27
28	TOTAL General Administration	379,449	26,921	1,835,672	2,242,042	2,242,042	(427,961)	1,814,081			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,551,906	258,748	2,997,500	6,808,154	6,808,154	(413,027)	6,395,127			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		150
			150
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	19,200
			19,200
18	DIRECTORS FEES		
	DIRECTORS FEES		0
			0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	88,200
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	82,825
			171,025
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	49,839
	EMPLOYEE WANT ADS	XIX F	22,224
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	18,812
	LICENSES & PERMITS	XIX F	5,546
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	920
	PATIENT BACKGROUND CHECKS	XIX F	260
			97,601
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		17,939
	EQUIPMENT REPAIR & MAINTENANCE		33,820
	OUTSIDE CLERICAL SERVICES		553,000
	PENALTIES / OVERDRAFT CHARGES	VI 18	14,481
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		11,872
	MESSENGER SERVICE		0
			631,112

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	267,855
	UNEMPLOYMENT COMPENSATION	XIX D	22,112
	WORKERS COMPENSATION INSURANCE	XIX D	75,683
	HOSPITALIZATION INSURANCE	XIX D	183,976
	EMPLOYEE BENEFITS - OTHER	XIX D	15,790
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
			565,416
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		8,050
			8,050
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		11,972
			11,972
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		199,377
			199,377
27	OTHER		
	BAD DEBTS	VI 24	131,919
			131,919

GRAND TOTAL COLUMN 3 OTHER

2,997,500

**WINDMILL NURSING PAVILION
SCHEDULES
12/31/2016**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	621
LESS SALES TAX	<u>(621)</u>
NET FOOD	0
TOTAL PATIENT CENSUS	40,934
TIMES 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	122,802
ADD # EMPLOYEE MEALS/DAY	
TIMES # DAYS	<u>54,900</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	122,802
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	122,802
NET FOOD	0
DIVIDE TOTAL MEALS/YEAR	<u>122,802</u>
COST PER MEAL	0.00
TIMES EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<u><u>0</u></u>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			89,926	89,926		89,926	171,712	261,638		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			101,660	101,660		101,660	216,233	317,893		32
33	Real Estate Taxes							480,672	480,672		33
34	Rent-Facility & Grounds			840,000	840,000		840,000	(840,000)			34
35	Rent-Equipment & Vehicles			16,047	16,047		16,047	12,670	28,717		35
36	Other (specify):*										36
37	TOTAL Ownership			1,047,633	1,047,633		1,047,633	41,287	1,088,920		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		126,106		126,106		126,106		126,106		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			305,204	305,204		305,204		305,204		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		126,106	305,204	431,310		431,310		431,310		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,551,906	384,854	4,350,337	8,287,097		8,287,097	(371,740)	7,915,357		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	114,240	30		9
10	Interest and Other Investment Income	(3,096)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(621)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(14,481)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(40,043)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(131,919)	27		24
25	Fund Raising, Advertising and Promotional	(49,839)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PG 5A	(47,442)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,201)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(198,539)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,539)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (371,740)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

ID# 0031823

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (47,340)	21	1
2	MARKETING TRAVEL	(102)	25	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(47,442)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(621)	0	0	0	0	0	0	0	0	0	0	(621)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,046	0	0	0	0	0	0	0	0	1,046	5
6	Maintenance	0	0	6,692	6,888	0	0	0	0	0	0	0	13,580	6
7	Other (specify):*	0	0	215	0	714	0	0	0	0	0	0	929	7
8	TOTAL General Services	(621)	0	7,953	6,888	714	0	0	0	0	0	0	14,934	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(19,200)	0	232,436	0	0	0	0	0	0	0	213,236	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(40,043)	0	5,878	0	0	0	0	0	0	0	0	(34,165)	19
20	Fees, Subscriptions & Promotions	(49,839)	0	1,692	0	0	0	0	0	0	0	0	(48,147)	20
21	Clerical & General Office Expenses	(61,821)	(553,000)	105,213	9,860	0	0	0	0	0	0	0	(499,748)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,950	0	0	0	0	0	0	0	0	1,950	24
25	Other Admin. Staff Transportation	(102)	0	1,630	0	0	0	0	0	0	0	0	1,528	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,117	0	0	0	0	0	0	0	0	3,117	26
27	Other (specify):*	(131,919)	0	17,615	0	48,572	0	0	0	0	0	0	(65,732)	27
28	TOTAL General Administration	(283,724)	(572,200)	137,095	242,296	48,572	0	0	0	0	0	0	(427,961)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(284,345)	(572,200)	145,048	249,184	49,286	0	0	0	0	0	0	(413,027)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	114,240	54,650	2,822	0	0	0	0	0	0	0	0	171,712	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,096)	216,873	2,456	0	0	0	0	0	0	0	0	216,233	32
33	Real Estate Taxes	0	476,550	4,122	0	0	0	0	0	0	0	0	480,672	33
34	Rent-Facility & Grounds	0	(840,000)	0	0	0	0	0	0	0	0	0	(840,000)	34
35	Rent-Equipment & Vehicles	0	0	12,670	0	0	0	0	0	0	0	0	12,670	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	111,144	(91,927)	22,070	0	0	0	0	0	0	0	0	41,287	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(173,201)	(664,127)	167,118	249,184	49,286	0	0	0	0	0	0	(371,740)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 19,200	DYNAMIC HEALTH CARE CONSULTANTS		\$	\$ (19,200)	1
2	V	21 BOOKKEEPING SERVICES	553,000	" " "			(553,000)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	840,000	16000 S WABASH LLC			(840,000)	7
8	V	32 INTEREST		" " "		216,873	216,873	8
9	V	33 REAL ESTATE TAXES		" " "		476,550	476,550	9
10	V	30 DEPRECIATION				54,650	54,650	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,412,200			\$ 748,073	\$ * (664,127)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 1,046	\$	1,046	15
16	V	6 REPAIR & MAINT.		" " "		6,692		6,692	16
17	V	7 EMP BEN-GEN SERV		" " "		215		215	17
18	V	19 PROFESSIONAL FEES		" " "		5,878		5,878	18
19	V	20 DUES AND SUBSCRIPTION		" " "		1,692		1,692	19
20	V	21 CLERICAL & GENERAL		" " "		105,213		105,213	20
21	V	24 SEMINARS AND TRAVEL		" " "		1,950		1,950	21
22	V	25 AUTO EXPENSE		" " "		1,630		1,630	22
23	V	26 INSURANCE		" " "		3,117		3,117	23
24	V	27 EMP. BEN. - GEN, ADMIN.		" " "		17,615		17,615	24
25	V	30 DEPRECIATION		" " "		2,822		2,822	25
26	V	32 INTEREST		" " "		2,456		2,456	26
27	V	33 REAL ESTATE TAXES		" " "		4,122		4,122	27
28	V	19 REAL ESTATE TAX PROTEST FEES		" " "					28
29	V	35 AUTO RENTAL		" " "		11,857		11,857	29
30	V	35 EQUIPMENT RENTAL		" " "		813		813	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 167,118	\$ *	167,118	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 MAINT COMP - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 6,888	\$ 6,888
16	V	17 ADMIN COMP - M MAUER		" " "		20,707	20,707
17	V	17 ADMIN COMP - M AARON		" " "		23,619	23,619
18	V	17 ADMIN COMP - F AARON		" " "		500	500
19	V	17 ADMIN COMP - D AARON		" " "		24,340	24,340
20	V	17 ADMIN COMP - S GOLDSTEIN		" " "			
21	V	17 ADMIN COMP - B FREIDMAN		" " "			
22	V	17 ADMIN COMP - R AARON		" " "		60,541	60,541
23	V	17 ADMIN COMP - S HARAMARAS		" " "		24,298	24,298
24	V	17 ADMIN COMP - D KUFTA		" " "		17,397	17,397
25	V	17 ADMIN COMP - HOWARD ALTER		" " "			
26	V	17 ADMIN COMP - NON OWNER - V DAVIS		" " "		13,773	13,773
27	V	17 ADMIN COMP - NON OWNER - A CASSATA		" " "			
28	V	17 ADMIN COMP - NON OWNER - VAR		" " "		21,861	21,861
29	V	17 ADMIN COMP - NON OWNER - CFO		" " "		25,400	25,400
30	V	21 CLERICAL COMP - S AARON		" " "		9,213	9,213
31	V	21 CLERICAL COMP - E MARYLES		" " "		647	647
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 249,184	\$ * 249,184

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	7 EMP BEN - D NEHMER	\$	DYNAMIC HEALTH CARE CONSULTANTS	100.00%	\$ 714	\$	714	15
16	V	27 EMP BEN - M MAUER		" " "		4,295		4,295	16
17	V	27 EMP BEN - M AARON		" " "		4,477		4,477	17
18	V	27 EMP BEN - F AARON		" " "		7,947		7,947	18
19	V	27 EMP BEN - D AARON		" " "		2,028		2,028	19
20	V	27 EMP BEN - S GOLDSTEIN		" " "					20
21	V	27 EMP BEN - B FREIDMAN		" " "					21
22	V	27 EMP BEN - R AARON		" " "		4,779		4,779	22
23	V	27 EMP BEN - S HARAMARAS		" " "		9,194		9,194	23
24	V	27 EMP BEN - D KUFTA		" " "		1,224		1,224	24
25	V	27 EMP BEN - HOWARD ALTER		" " "					25
26	V	27 EMP BEN - V DAVIS		" " "		3,479		3,479	26
27	V	27 EMP BEN - A CASSATA		" " "					27
28	V	27 EMP BEN - NON OWNER		" " "		6,185		6,185	28
29	V	27 EMP BEN - NON OWNER - CFO		" " "		2,669		2,669	29
30	V	27 EMP BEN - S AARON		" " "		1,896		1,896	30
31	V	27 EMP BEN - E MARYLES		" " "		399		399	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 49,286	\$ *	49,286	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SUSAN STERN	4.	BRADLEY		16000 S WABASH LIMITED PTRNSHP		BUILDING CO	1
2	ABRAHAM STERN	4.	BRIDGEVIEW HEALTH CARE CENTER		DYNAMIC HEALTH	SKOKIE	BOOKKEEPING/C	2
3	MAURICE AARON	29.6	GROSS POINTE MANOR LLC		SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4	FRED AARON	9.2	OTTAWA PAVILION LTD					4
5	MIRIAM LATINIK	6.67	PARK RIDGE CARE CENTER LTD					5
6	MARIKA NISSAN	3.33	STERLING PAVILION LTD					6
7	MARSHALL MAUER	6.67	WARREN PARK HEALTH AND LIVING CENTER LLC					7
8	FRANCES MAUER	6.67	WATERFRONT TERRACE INC					8
9	HOWARD GELLER	1.67	WOODBIDGE NURSING PAVILION LTD					9
10	NOAH WOLF	1.67	WOODRIDGE SUPPORTING LIVING RESIDENCE OF GALESBURG					10
11	SHARON AARON	.733	WOODRIDGE SUPPORTING LIVING RESIDENCE OF GENESEO					11
12	CHANA MAUER-RAY	7.92						12
13	DENNIS NEHMER	.733						13
14	DIANIA KUFTA	.733						14
15	ESTHER MARYLES	7.92						15
16	TJE 2000 TRUST-EVAN STERN	2.						16
17	HOWIE & SUSIE ALTER	1.47						17
18	TJE 2000 TRUST-JONATHAN STERN	2.						18
19	SYLVIA AARON	.29						19
20	SUE KOPLIN HARAMARAS	.73						20
21	THE 2000 TRUST-TODD STERN	2.						21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER	SHAREHOLDER	ADMINISTRATIV	6.67	SCHEDULE	4.14	8.28	SALARY	\$ 20,707	17-7	1
2	MAURICE AARON	SHAREHOLDER	ADMINISTRATIV	29.60	ATTACHED	4.72	9.45	SALARY	23,619	17-7	2
3	FRED AARON	SHAREHOLDER	ADMINISTRATIV	9.20		9		SALARY	42,000	21-1	3
4	FRED AARON	SHAREHOLDER	ADMINISTRATIVE					SALARY	500	17-7	4
5	SHARON AARON	SHAREHOLDER	CLERICAL	0.73		4.14	10.35	SALARY	9,213	21-7	5
6	DENNIS NEHMER	SHAREHOLDER	MAINTENANCE	0.73		4.72	11.81	SALARY	6,888	6-7	6
7	DIANIA KUFTA	SHAREHOLDER	ADMINISTRATIV	0.73		5.9	11.81	SALARY	17,397	17-7	7
8	ESTHER MARYLES	SHAREHOLDER	CLERICAL	7.92		0.29	1.04	SALARY	647	21-7	8
9	DANIEL AARON	RELATED PARTY	ADMINISTRATIVE			12.72	31.79	SALARY	24,340	17-7	9
10	SUE KOPLIN HARAMARAS	SHAREHOLDER	ADMINISTRATIV	0.73		10		SALARY	24,298	17-7	10
11	ROBERT AARON	RELATED PARTY	CLERICAL			40		SALARY	60,541	17-7	11
12											12
13								TOTAL	\$ 230,150		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	415,748	13	\$ 10,619	\$ 40,934	\$ 1,046	1	
2	6	REPAIR & MAINT.	PATIENT DAYS	415,748	13	67,972	32,339	40,934	6,692	2
3	7	EMP BEN-GEN SERV	PATIENT DAYS	415,748	13	2,182	40,934	215	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	415,748	13	59,702	40,934	5,878	4	
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	415,748	13	17,185	40,934	1,692	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	415,748	13	1,068,604	741,401	40,934	105,213	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	415,748	13	19,810	40,934	1,950	7	
8	25	AUTO EXPENSE	PATIENT DAYS	415,748	13	16,560	40,934	1,630	8	
9	26	INSURANCE	PATIENT DAYS	415,748	13	31,660	40,934	3,117	9	
10	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	415,748	13	178,906	40,934	17,615	10	
11	30	DEPRECIATION	PATIENT DAYS	415,748	13	28,663	40,934	2,822	11	
12	32	INTEREST	PATIENT DAYS	415,748	13	24,945	40,934	2,456	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	415,748	13	41,869	40,934	4,122	13	
14	19	REAL ESTATE TAX PROTEST FE	PATIENT DAYS	415,748	13		40,934	0	14	
15	35	AUTO RENTAL	PATIENT DAYS	415,748	13	120,431	40,934	11,857	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	415,748	13	8,254	40,934	813	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,697,362	\$ 773,740	\$ 167,118	25	

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	9	\$ 58,328	\$ 58,328	5	\$ 6,888	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	11	200,000	200,000	4	20,707	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	9	200,000	200,000	5	23,619	3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500	9	500	4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	40	3	76,541	76,541	13	24,340	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	182,833	182,833			6
7	17	ADMIN COMP - B FREIDMAN	WGHTD AVG HOURS	40	1	200,000	200,000			7
8	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	40	1	60,541	60,541	40	60,541	8
9	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	72,895	72,895	10	24,298	9
10	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	50	8	147,459	147,459	6	17,397	10
11	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			11
12	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	10	133,035	133,035	4	13,773	12
13	17	ADMIN COMP - NON OWNER - A	WGHTD AVG HOURS	40	1	94,167	94,167			13
14	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	45	8	185,179	185,179	5	21,861	14
15	17	ADMIN COMP - NON OWNER - C	WGHTD AVG HOURS	40	10	245,335	245,335	4	25,400	15
16	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	10	89,040	89,040	4	9,213	16
17	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	28	11	62,541	62,541	0	647	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,022,394	\$ 2,022,394		\$ 249,184	25

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTH CARE CONSULTANTS
 Street Address 3359 W MAIN STREET
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D NEHMER	WGHTD AVG HOURS	40	9	\$ 6,047	5	\$ 714	1
2	27	EMP BEN - M MAUER	WGHTD AVG HOURS	40	11	41,488	4	4,295	2
3	27	EMP BEN - M AARON	WGHTD AVG HOURS	40	9	37,909	5	4,477	3
4	27	EMP BEN - F AARON	WGHTD AVG HOURS	45	5	39,733	9	7,947	4
5	27	EMP BEN - D AARON	WGHTD AVG HOURS	40	3	6,379	13	2,028	5
6	27	EMP BEN - S GOLDSTEIN	WGHTD AVG HOURS	40	2	36,760			6
7	27	EMP BEN - B FREIDMAN	WGHTD AVG HOURS	40	1	10,395			7
8	27	EMP BEN - A CASSATA	WGHTD AVG HOURS	40	1	4,779	40	4,779	8
9	27	EMP BEN - S HARAMARAS	WGHTD AVG HOURS	30	3	27,583	10	9,194	9
10	27	EMP BEN - D KUFTA	WGHTD AVG HOURS	50	8	10,371	6	1,224	10
11	27	EMP BEN - HOWARD ALTER	WGHTD AVG HOURS	40	1	1,060			11
12	27	EMP BEN - V DAVIS	WGHTD AVG HOURS	40	10	33,608	4	3,479	12
13	27	EMP BEN - A CASSATA	WGHTD AVG HOURS	40	1	7,352			13
14	27	EMP BEN - NON OWNER	WGHTD AVG HOURS	45	8	52,388	5	6,185	14
15	27	EMP BEN - NON OWNER - CFO	WGHTD AVG HOURS	40	10	25,777	4	2,669	15
16	27	EMP BEN - S AARON	WGHTD AVG HOURS	40	10	18,319	4	1,896	16
17	27	EMP BEN - E MARYLES	WGHTD AVG HOURS	28	11	38,523	0	399	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 398,471	\$	\$ 49,286	25

Facility Name & ID Number

WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	MB FINANCIAL		X	MORTGAGE	\$27,748.05	7/1/12	\$ 4,833,000	\$ 4,536,100	10/10/20	4.2500	\$ 210,519	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	MB FINANCIAL		X		INTEREST ONLY		500,000	500,000	10/10/20	5.0000	6,354	6						
7	MB FINANCIAL		X	WORKING CAPITAL							24,160	7						
8	RELATED PARTY	X		WORKING CAPITAL							79,956	8						
9	TOTAL Facility Related				\$27,748.05		\$ 5,333,000	\$ 5,036,100			\$ 320,989	9						
B. Non-Facility Related*																		
10	IRS,IDR,ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,333,000	\$ 5,036,100			\$ 320,989	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 report.		\$	440,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	453,550	2
3. Under or (over) accrual (line 2 minus line 1).		\$	13,550	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	463,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>200</u> For <u> </u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	476,550	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	<u>439,041</u>	8	
	2012	<u>476,614</u>	9	
	2013	<u>493,215</u>	10	
	2014	<u>428,802</u>	11	
	2015	<u>453,550</u>	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2015 TAX BILL.				
	FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>29-15-302-051-0000</u>	<u>NURSING HOME</u>	\$ <u>453,549.55</u>	\$ <u>453,549.55</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>453,549.55</u></u>	\$ <u><u>453,549.55</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: NURSING HOME, 408,821. Row 3: TOTALS, 408,821.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	150	1986	1976	\$ 3,187,988	\$	30	\$ 106,266	\$ 106,266	\$ 2,869,182	4
5										5
6										6
7	RELATED PARTY			43,676	1,120	35	1,248	128	29,117	7
8										8
Improvement Type**										
9	LEASEHOLD IMPROVEMENT		1989	6,334	201	31.5	201		5,519	9
10	LEASEHOLD IMPROVEMENT		1990	1,538	49	20		(49)	1,538	10
11	LEASEHOLD IMPROVEMENT		1991	26,695	847	20		(847)	26,695	11
12	LEASEHOLD IMPROVEMENT		1992	4,785	152	20		(152)	4,785	12
13	LEASEHOLD IMPROVEMENT		1993	8,024	255	31.5	255		6,060	13
14	LEASEHOLD IMPROVEMENT		1993	36,822	944	39	944		22,053	14
15	LEASEHOLD IMPROVEMENT		1994	38,826	996	39	996		22,105	15
16	LEASEHOLD IMPROVEMENT		1995	21,539	553	39	553		11,979	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR		1996	1,604	41	39	41		853	17
18	ROOF REPAIR		1996	3,800	97	39	97		1,986	18
19	GAZEBO		1996	1,282	33	39	33		672	19
20	ASPHALT REMOVE & REPLACE		1996	2,686	69	39	69		1,401	20
21	ROOF REPAIR		1996	7,000	180	39	180		3,645	21
22	HOT WATER TANK		1996	12,098	310	39	310		6,238	22
23	CABINETS, SINK, COUNTERTOP, SHELVES		1997	6,844	175	39	175		3,377	23
24	REHAB ROOM, FLOORING,HAND RAILS		1997	105,092	2,695	39	2,695		62,067	24
25	ROOFING		1997	45,500	1,167	39	1,167		22,516	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS		1997	4,721	121	39	121		2,334	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS		1997	26,497	679	39	679		13,090	27
28	FIRE ALARM REPAIR, DOOR ALARM		1998	3,359	86	39	86		1,584	28
29	DRAPES & INSTALLATION		1998	5,965	153	39	153		2,809	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS		1998	14,240	365	39	365		6,704	30
31	EXHAUST FAN & INSTALLATION		1998	2,285	59	39	59		1,074	31
32	ROOF REPAIR		1998	8,750	224	39	224		4,118	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS		1998	22,500	577	39	577		10,618	33
34	ELECTRICAL WORK		1998	5,376	138	39	138		2,533	34
35	COUNTER TOPS		1998	712	18	39	18		230	35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	PARKING LOT IMPROVEMENT	1998	\$ 1,185	\$ 31	39	\$ 31		\$ 553	37
38	NURSES STATION	1999	16,601	426	39	426		7,650	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		2,094	39
40	FIRE SYSTEM	1999	2,625	67	39	67		1,202	40
41	FLOOR TILE	1999	10,807	277	39	277		5,975	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		4,360	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		3,970	43
44	AIR CONDITIONING	1999	14,451	371	39	371		6,565	44
45	RAILINGS	1999	3,282	84	39	84		1,481	45
46	ROOF WORK	1999	4,500	115	39	115		1,989	46
47	NURSE STATION	2000	7,090	258	27.5	258		4,269	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		3,826	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		5,037	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		1,555	50
51	SMOKE DETECTOR	2000	3,473	126	27.5	126		2,084	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	228	15	418	190	6,479	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		3,168	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		3,218	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		1,627	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		3,202	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		1,350	57
58	CONCRETE PAD	2002	1,662	69	15	111	42	1,608	58
59	ELECTRIC MOTOR	2002	714	26	27.5	26		373	59
60	WALL HEATER / AC	2002	3,705	135	27.5	135		1,908	60
61	ROOF REPAIRS	2002	5,550	202	27.5	202		2,903	61
62	WALL AIR CONDITIONER	2003	2,277	83	27.5	83		1,117	62
63	DOOR LOCK ON FIRE DOOR	2003	2,116	77	27.5	77		1,036	63
64	HEATING COOLING SYSTEM REPAIRS	2003	8,018	291	27.5	291		3,919	64
65	COMPRESSOR & CONDENSOR	2004	3,832	139	27.5	139		1,732	65
66	SHEET VINYL & COVE BASE	2004	19,015	692	27.5	692		8,621	66
67	ROOF REPAIRS	2004	13,586	494	27.5	494		6,154	67
68	AIR CONDITIONING	2004	664	24	27.5	24		299	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,850,922	\$ 18,560		\$ 124,138	\$ 105,578	\$ 3,248,206	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,850,922	\$ 18,560		\$ 124,138	\$ 105,578	\$ 3,248,206	1
2	WATER HEATER, VALVE & PUMPS	2004	6,594	240	27.5	240		2,990	2
3	FIRE DOORS	2004	769	28	27.5	28		349	3
4	AIR PUMP/BOILER AND ELECTRIC REPAIR	2005	7,659	278	27.5	278		3,185	4
5	ROOFTOP CONDENSOR/ROOF REPAIR	2005	10,565	384	27.5	384		4,401	5
6	FIRE ALARM REPAIRS	2005	1,449	53	27.5	53		607	6
7	WALL AIR CONDITIONER	2005	1,892	69	27.5	69		790	7
8	DOOR SOUNDERS/DYNA LOCK	2006	2,866	104	27.5	104		1,088	8
9	REWIRING LIGHTS/OUTLETS	2006	3,240	118	27.5	118		1,234	9
10	WALL AIR CONDITIONER	2006	2,835	103	27.5	103		1,077	10
11	CONCRETE SIDEWALKS	2006	19,403	1,294	15	1,294		13,587	11
12	LANDSCAPING	2006	10,250	683	15	683		7,172	12
13	FREEZER COMPRESSOR	2006	1,000	36	27.5	36		376	13
14	SEWER, PIPE WORK, BOILER	2006	6,499	236	27.5	236		2,468	14
15	EXIT SIGNS	2006	1,316	48	27.5	48		502	15
16	REPAIR FENCE	2006	2,000	133	15	133		1,396	16
17	FIRE DOORS	2006	1,058	39	27.5	39		408	17
18	CONCRETE WORK	2006	2,200	80	27.5	80		837	18
19	GAZEBO	2007	4,671	311	15	311		2,955	19
20	DISH NETWORK CABLING	2007	19,000	691	27.5	691		6,536	20
21	WALL AIR CONDITIONER	2007	3,374	123	27.5	123		1,163	21
22	SECURITY DOORS	2007	4,837	176	27.5	176		1,665	22
23	PARKING LOT PAVING	2007	4,492	163	27.5	163		1,542	23
24	WATER SOFTENER, WATER HEATER	2007	2,288	83	27.5	83		785	24
25	HEATING COIL, ELECTRICAL WORK	2007	3,837	140	27.5	140		1,324	25
26	CAMERA SYSTEM	2008	8,020	292	27.5	292		2,469	26
27	FIRE RELEASE DOOR ALARMS	2008	2,350	85	27.5	85		719	27
28	WALLPAPER & PLASTERING	2008	14,140	514	27.5	514		4,348	28
29	AC/HEATER UNITS	2008	6,221	226	27.5	226		1,912	29
30	DOOR & FRAME	2008	2,113	77	27.5	77		651	30
31	MIXING VALVE, PUMP REPAIR	2008	15,340	558	27.5	558		4,720	31
32	DISH NETWORK EQUIPMENT	2009	3,748	136	27.5	136		1,014	32
33	AC / HEAT WALL UNITS	2009	5,321	194	27.5	194		1,447	33
34	TOTAL (lines 1 thru 33)		\$ 4,032,269	\$ 26,255		\$ 131,833	\$ 105,578	\$ 3,323,923	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,032,269	\$ 26,255		\$ 131,833	\$ 105,578	\$ 3,323,923	1
2	ELECTRICAL WORK	2009	33,206	1,207	27.5	1,207		9,002	2
3	SECURITY SYSTEM REPAIRS	2009	9,610	349	27.5	349		2,603	3
4	ROOF & GUTTER REPAIRS	2009	9,355	341	27.5	341		2,543	4
5	DOORS	2009	1,108	40	27.5	40		298	5
6	DRYWALL, WALLPAPER, PAINT	2009	41,872	1,523	27.5	1,523		11,359	6
7	PLUMBING REPAIRS	2009	13,689	498	27.5	498		3,714	7
8	TILE & CARPET	2009	25,956	944	27.5	944		7,041	8
9	LIGHT FIXTURES, WINDOW TREATMENTS	2009	206,165	7,496	27.5	7,496		55,909	9
10	SECURITY ALARM-NEW KEY & CONTROLS,CAMERA	2010	3,175	116	27.5	116		749	10
11	SECURITY SYSTEM-EGRESS DOOR,MONITOR,CAMERAS	2010	3,050	111	27.5	111		717	11
12	HOT WATER HEATER,TANK AND VALVES	2010	10,658	388	27.5	388		2,506	12
13	WALL AIR CONDITIONERS	2010	5,675	207	27.5	207		1,337	13
14	INSTALLED MODULATING MOTOR, BOILER PUMP MOTO	2010	3,611	131	27.5	131		846	14
15	REPLACED 8 HEAT DETECTORS	2010	1,875	68	27.5	68		439	15
16	NEW GAS VALVES ON ROOFTOP UNIT, HEATING REPAIR	2010	3,000	109	27.5	109		704	16
17	WATER MIXING VALVE, DIETARY SHERFING & BRACKET	2010	1,828	65	27.5	65		420	17
18	HEAT/COOL UNITS	2011	6,170	224	27.5	224		1,223	18
19	DOORS	2011	6,838	249	27.5	249		1,359	19
20	FIRE DAMPER/SECURITY SYSTEM WORK	2011	7,432	270	27.5	270		1,474	20
21	BOILER/HOT WATER HEATER	2011	20,909	760	27.5	760		4,148	21
22	SCANNER	2011	21,943	798	27.5	798		4,356	22
23	AMP METER ON GENERATOR	2011	1,969	72	27.5	72		393	23
24	WALL SINK	2011	910	33	27.5	33		180	24
25	CONCRETE WORK	2011	3,784	138	27.5	138		753	25
26	ELECTRIC WORK	2012	4,315	155	27.5	155		692	26
27	HEATING & AIRCONDITIONING	2012	6,231	226	27.5	226		1,008	27
28	SECURITY SYSTEM WORK	2012	965	38	27.5	38		168	28
29	GENERATOR INSTALL	2013	29,045	1,056	27.5	1,056		3,649	29
30	FIRE DOOR, ALARM SYSTEM, OPENERS, DOOR CURTAIN	2013	11,860	431	27.5	431		1,487	30
31	AIR CONDITIONERS	2013	6,025	219	27.5	219		754	31
32	LAUNDRY DUCT WORK, EXHAUST FAN	2013	3,886	141	27.5	141		488	32
33	PARKING LOT ASPHALT	2013	4,800	175	27.5	175		600	33
34	TOTAL (lines 1 thru 33)		\$ 4,543,184	\$ 44,833		\$ 150,411	\$ 105,578	\$ 3,446,842	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward		\$ 4,543,184	\$ 44,833		\$ 150,411	\$ 105,578	\$ 3,446,842	1
2	ROOF REPAIR	2013	7,075	258	27.5	258		892	2
3	WIRING WRAP	2013	1,286	47	27.5	47		175	3
4	LED FLOOD LIGHTS	2013	580	21	27.5	21		101	4
5	RELATED PARTY - 16000 S WABASH LLC								5
6	1st FLOOR RESIDENT RMS-PAINT, PLASTER, FLOORING, LIGHTING,WARDROBES,ELECTRICAL,NURSE CALL SWITHCES								6
7		2013	229,186	8,334	27.5	8,334		33,336	7
8	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								8
9		2013	173,989	6,326	27.5	6,326		24,876	9
10	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								10
11		2013	12,775	465	27.5	465		1,860	11
12	SPRINKLER & FIRE ALARM INSTAL, REPAIR	2013	168,824	6,139	27.5	6,139		24,556	12
13	AC UNIT IN DINING ROOM	2013	3,830	139	27.5	139		556	13
14	SHOWER ROOM PLUMBING, NEW DRAINS	2013	6,595	240	27.5	240		960	14
15	THERAPY ROOM-DROP CEILING & LIGHTING	2013	5,367	195	27.5	195		780	15
16	ROOFTOP HEAT & AIR UNITS	2013	19,484	709	27.5	709		2,836	16
17	HALLWAYS-DOUBLE DOORS, ENTRY DOORS, WATER FOUNTAIN PLUMBING, TILE & GROUT, LIGHTING								17
18		2013	19,141	696	27.5	696		2,784	18
19	ASBESTOS REMOVAL- ONE WING, RESIDENT ROOMS	2013	64,345	2,340	27.5	2,340		9,360	19
20									20
21	1st & 2nd FLOOR RESIDENT RMS-PAINT, PLASTER, FLOORING, LIGHTING,WARDROBES,ELECTRICAL,NURSE CALL SWITHCES								21
22		2013	298,401	10,851	27.5	10,851		43,404	22
23	RESIDENT BATHROOMS-FLOOR & WALL TILE, GRAB BARS, TOILETS, SINKS, PAINT, EXHAUST FANS, LIGHTING								23
24		2013	122,981	4,472	27.5	4,472		17,888	24
25	NURSE STATION BATHROOMS-DRAINS, WALL & FLOOR TILE, TOILETS, SINKS, LIGHTING, DROP CEILING, GRAB BARS								25
26		2013	15,077	548	27.5	548		2,192	26
27	DINING ROOM WINDOW TREATMENTS SPRINKLER HEADS,WALL PROTECTOR								27
28		2013	32,844	1,194	27.5	1,194		4,776	28
29	TILE & GLASS BLOCK SHOWER ROOMS	2013	53,303	1,938	27.5	1,938		7,752	29
30	THERAPY ROOM WHIRLPOOL TUB & SPRINKLER HEADS	2013	9,087	330	27.5	330		1,320	30
31	HALLWAYS-HINGES & PROTECTION SYSTEM	2013	4,332	158	27.5	158		632	31
32	ASBESTOS REMOVAL- 2ND FLOOR RESIDENT ROOMS	2013	16,815	611	27.5	611		2,444	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,808,501	\$ 90,844		\$ 196,422	\$ 105,578	\$ 3,630,322	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,808,501	\$ 90,844		\$ 196,422	\$ 105,578	\$ 3,630,322	1
2	OFFICES-ELECTRICAL WORK IN OFFICES AND								2
3	ROOM 210	2014	32,986	1,199	27.5	1,199		2,948	3
4	NEW OFFICE - CUBICLES INSTALL	2014	12,429	452	27.5	452		1,111	4
5	AIR CONDITIONERS	2014	3,166	115	27.5	115		283	5
6	NATURAL GAS GENERATOR REPLACEMENT; REMOVE AND								6
7	TRANSFER SWITCH FOR NEW GENERATOR	2014	33,922	1,234	27.5	1,234		3,033	7
8	ROOMS 101,102,103,104,201,202,203,204-LOCKER UNITS								8
9	INSTALLATION	2014	29,126	1,059	27.5	1,059		2,604	9
10	SPRINKLER SYSTEM REPAIR; INSTALLED FIRE SYSTEM	2014	4,429	161	27.5	161		396	10
11	SECURITY SYSTEM WORK; REPLACED CAMERA'S, PARTS,								11
12	MONITOR, DVD RECORDER, CABLE, PHONE	2014	13,094	476	27.5	476		1,170	12
13	PLUMBING WORK AND SUPPLIES; INSTALLED FLOOD								13
14	GUARDS, EYEWASH STATION, REGULATORS INTO GAS LINE,								14
15	NEW PLUG IN CLEAN OUTS, FIXED SINKS & TAILETS,								15
16	REPAIR POWER OUTAGE	2014	36,503	1,327	27.5	1,327		3,262	16
17	WALLCOVERING, WALL PLATE, DOOR, CARPET PAD	2014	2,843	103	27.5	103		253	17
18	NURSES STATION; INSTALL ANNUNCIATER	2014	1,797	65	27.5	65		160	18
19	FURNISH LABOR & MATERIAL TO INCREASE PRESSURE								19
20	TO 2 PSI	2014	2,139	78	27.5	78		192	20
21									21
22	RELATED PARTY-16000 S WABASH LLC								22
23	RESIDENTS ROOMS # 121,202,203,205,206,209,211,212,213,216,217,303,312,316,317- WALLPAPER, DRYWALL,PLASTER,FLOORING,SWITHCES,L								23
24		2014	69,377	2,523	27.5	2,523		6,203	24
25	RESIDENTS BATHROOMS #203,213 ,COMMUNITY BATHROOM -PLUMBING,FINISH TRIM,MAKE BIGER SIZE								25
26		2014	14,488	527	27.5	527		1,295	26
27	DINING ROOM # 200-PAINT,DROP CEILING,DRYWALL,LIGHTING								27
28		2014	41,004	1,491	27.5	1,491		3,666	28
29	BEAUTY SHOP-FLOORING,WALLCOVERING,DRYWALL,VANITY, BOWL AND SINK								29
30		2014	14,068	512	27.5	512		1,259	30
31	LANDSCAPING RENOVATION/DESIGN-WIDEN THE EXISTING PAVER SIDEWALK,INSTALL NEW SHRUBS, PERENNIALS,SOD,STONE BORI								31
32		2014	20,147	1,343	15	1,343		4,030	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,140,019	\$ 103,509		\$ 209,087	\$ 105,578	\$ 3,662,187	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION

0031823

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,140,019	\$ 103,509		\$ 209,087	\$ 105,578	\$ 3,662,187	1
2	ROOF-RE-ROOFED PROPERTY USING DURO LAST ROOFING SYSTEMS,REPLACED 350 FEET OF WOOD, INSTALL 3 NEW SCUPPER DRAIN								2
3		2014	46,282	1,683	27.5	1,683		4,138	3
4	OFFICES/SOCIAL SERVICE WING-FLOORING,PAINT,PLASTER,WALLCOVERING,CUBICLES,CARPETING, DRYWALL, BUILD CLOSET								4
5		2014	16,495	600	27.5	600		1,475	5
6	OFFICE-HUTCH,ELECTRICAL,WINDOW TREATMENTS,LIGHTING,PICTURES,WALLCOVERING								6
7		2015	9,332	261	39	261		381	7
8	WALL UNIT AC	2015	5,246	146	39	146		213	8
9	ELECTRICAL WORKFAMILY WAITING ROOM,BATH HOU	2015	19,576	546	39	546		797	9
10	FLAT SCREEN TV & MOUNTING BRACKET	2015	1,840	51	39	51		75	10
11	FLOORING,LIGHTING-DINING RM, CONFERENCE RM, SO	2015	7,171	200	39	200		292	11
12	FENCE	2015	1,475	41	39	41		60	12
13	FIRE DOORS, CAMERAS	2015	13,020	363	39	363		530	13
14	CONDENSER, KITCHEN HOOD FILTER RACK,PUMP	2015	13,331	372	39	372		543	14
15	PARKING LOT SEALED	2015	690	19	39	19		28	15
16	OUTDOOR SINAGE	2015	20,571	574	39	574		838	16
17	ASBESTOS ABATEMENT	2015	30,445	571	39	571		961	17
18	RESIDENT ROOM FLOORING,WALLPAPER,CORNER GUAR	2016	8,450	130	39	130		130	18
19	ARTWORK/MIRRORS/OVERBED LIGHTS	2016	1,637	28	39	28		28	19
20	THERAPY RM FLOORING,WALLPAPER,ELECTRICAL WO	2016	45,399	540	39	540		540	20
21	LOBBY FLOORING/WALLPAPER	2016	2,743	35	39	35		35	21
22	DIALYSIS SUITE FLOORING,WALLPAPER,CORNER GUAR	2016	5,781	56	39	56		56	22
23	SINK	2016	689	12	39	12		12	23
24	WALL PIPE, AIR CONDITIONER,SPRINKLER WORK	2016	4,903	28	39	28		28	24
25	ACTIVITY ROOM DROP CEILING, WALLPAPER	2016	5,000	64	39	64		64	25
26	DINING ROOM WALLPAPER, DROP CEILING	2016	15,625	100	39	100		100	26
27	DOOR	2016	1,139	7	39	7		7	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,416,859	\$ 109,936		\$ 215,514	\$ 105,578	\$ 3,673,518	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 448,356	\$ 30,595	\$ 39,880	\$ 9,285	10	\$ 267,463	71
72	Current Year Purchases	51,647	5,165	2,582	(2,583)	10	2,582	72
73	Fully Depreciated Assets	652,462					652,462	73
74	RELATED PARTY	91,342	1,702	3,662	1,960		89,427	74
75	TOTALS	\$ 1,243,807	\$ 37,462	\$ 46,124	\$ 8,662		\$ 1,011,934	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,069,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 261,638	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 114,240	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,685,452	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 16,047 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				107,194		107,194	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): MED SUPPLIES, LAB ETC						18,912		18,912	13
14	TOTAL			\$		\$	126,106		\$ 126,106	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 1,355,250	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 360,000)	1,061,642	1,061,642	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	113,147	113,147	6
7	Other Prepaid Expenses	9,272	10,703	7
8	Accounts Receivable (owners or related parties)	65,541	180,070	8
9	Other(specify): RE TAX ESCROW		255,674	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,249,602	\$ 2,976,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,821	13
14	Buildings, at Historical Cost		3,187,988	14
15	Leasehold Improvements, at Historical Cost	1,690,243	3,512,867	15
16	Equipment, at Historical Cost	1,195,550	1,260,550	16
17	Accumulated Depreciation (book methods)	(1,592,376)	(5,538,006)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		71,163	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(58,202)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CONSTRUCTION)		1,183,732	22
23	Other(specify): DEPOSITS	38,018	38,018	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,331,435	\$ 4,066,931	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,581,037	\$ 7,043,417	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 624,172	\$ 624,172	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	644,122	644,122	29
30	Accrued Salaries Payable	278,094	278,094	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,085	14,085	31
32	Accrued Real Estate Taxes(Sch.IX-B)		463,000	32
33	Accrued Interest Payable	9,388	9,388	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY PAYABLE	2,061,029	2,124,029	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,630,890	\$ 4,156,890	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		500,000	39
40	Mortgage Payable		4,536,100	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,036,100	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,630,890	\$ 9,192,990	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,049,853)	\$ (2,149,573)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,581,037	\$ 7,043,417	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (943,001)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (943,001)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,852)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (106,852)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,049,853)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,627,659	1
2	Discounts and Allowances for all Levels	(35,075)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,592,584	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	213,217	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 213,217	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,096	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,096	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,808,897	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,232,383	31
32	Health Care	3,333,729	32
33	General Administration	2,242,042	33
B. Capital Expense			
34	Ownership	1,047,633	34
C. Ancillary Expense			
35	Special Cost Centers	126,106	35
36	Provider Participation Fee	305,204	36
D. Other Expenses (specify):			
37	PRIOR PERIOD EXPENSE	(371,348)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,915,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,852)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,852)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,156,520	44
45	Private Pay - Net Inpatient Revenue	291,770	45
46	Medicare - Net Inpatient Revenue	1,788,213	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	30,030	47
48	Other-(specify) VETERAN	326,051	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,592,584	49

****TAX RETURN PREPARED ON CASH BASIS**

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? **NO**** If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **WINDMILL NURSING PAVILION**

0031823

Report Period Beginning: 01/01/2016

Ending:

12/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,881	2,141	\$ 114,715	\$ 53.58	1
2	Assistant Director of Nursing	1,958	2,017	81,461	40.39	2
3	Registered Nurses	6,592	6,845	230,415	33.66	3
4	Licensed Practical Nurses	34,385	37,759	1,061,068	28.10	4
5	CNAs & Orderlies	71,601	78,200	989,565	12.65	5
6	CNA Trainees					6
7	Licensed Therapist	7,897	8,392	372,979	44.44	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,922	2,017	34,804	17.26	9
10	Activity Assistants	8,833	9,419	96,563	10.25	10
11	Social Service Workers	3,556	3,701	90,588	24.48	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,955	2,047	89,727	43.83	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,974	2,137	103,254	48.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,915	11,761	276,195	23.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	453	454	10,572	23.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,922	166,890	\$ 3,551,906 *	\$ 21.28	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 0	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	9,004	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,418	11-3	44
45	Social Service Consultant	E	4,583	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,005		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

WINDMILL NURSING PAVILION
 SCHEDULE-LEGAL
 12/31/2016

DATE	NAME	DESCRIPTION	AMOUNT
1/1/2016	MUCH SHELIST	CORPORATE MAINTENANCE	125.00
4/1/2016	MUCH SHELIST	GENERAL COUNSELING	375.00
5/1/2016	MUCH SHELIST	GENERAL COUNSELING	112.50
5/31/2016	MUCH SHELIST	GENERAL COUNSELING	487.50
6/30/2016	MUCH SHELIST	GENERAL COUNSELING	75.00
8/31/2016	MUCH SHELIST	GENERAL COUNSELING	1,100.00
9/30/2016	MUCH SHELIST	GENERAL COUNSELING	487.50
11/30/2015	MUCH SHELIST	GENERAL COUNSELING	350.00
10/31/2016	MUCH SHELIST	GENERAL COUNSELING	75.00
12/31/2016	MUCH SHELIST	GENERAL COUNSELING	1,050.00
6/8/2016	SIDNEY R. BERGER	COLLECTIONS	450.00
2/29/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	89.59
2/29/2016	SIMANDL LAW GROUP	FACILITY AUDITS	241.34
3/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	535.00
4/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	2,299.50
5/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	25.13
5/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	1,140.69
6/30/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	8.18
6/30/2016	SIMANDL LAW GROUP	FACILITY AUDITS	457.05
7/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	320.41
10/31/2016	SIMANDL LAW GROUP	LABOR AND EMPLOYMENT	1.92
10/31/2016	SIMANDL LAW GROUP	FACILITY AUDITS	126.65
10/31/2016	SIMANDL LAW GROUP	GENERAL SERVICE	14.54
1/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	337.50
2/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	180.00
3/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	65.20
4/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	4,476.75
4/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	570.50
6/1/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	3,724.36
6/1/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	315.00
6/1/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	425.00
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,854.70
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	207.50
6/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,053.95
7/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,883.58
7/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,076.28
7/29/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	967.77
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	5,257.05
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	105.17
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	150.00
8/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	250.00
9/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,102.60
9/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,067.50
10/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	3,479.03
10/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	265.00
10/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	750.00
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	3,029.40
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	170.49
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	175.00
11/30/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	2,525.49
12/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	45.00
12/31/2016	STONE POGRUND & KIREY	GENERAL LITIGATION & COLLECTIONS	1,082.90
			<u>49,540.22</u>

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$15,570
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,512 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 305,204
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees